

		FOR OHF USE					

LL 1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0015651</u></p> <p>Facility Name: <u>Bethany Terrace Ret & N H</u></p> <p>Address: <u>8425 North Waukegan</u> <u>Morton Grove</u> <u>60053</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(847) 965-8100</u> Fax # ()</p> <p>IDPA ID Number: <u>36-2012788</u></p> <p>Date of Initial License for Current Owners: <u>2/13/69</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Harold Reisler</u> Telephone Number: <u>(773) 989-1465</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/00</u> to <u>9/30/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1150 678 1283 829" rowspan="2">Officer or Administrator of Provider</td> <td data-bbox="1283 678 1923 716">(Signed) _____ (Date)</td> </tr> <tr> <td data-bbox="1283 716 1923 753">(Type or Print Name) <u>Wolfgang Mayer</u></td> </tr> <tr> <td data-bbox="1150 829 1283 878"></td> <td data-bbox="1283 753 1923 802">(Title) <u>Vice President</u></td> </tr> <tr> <td data-bbox="1150 878 1283 1040" rowspan="4">Paid Preparer</td> <td data-bbox="1283 829 1923 878">(Signed) _____ (Date)</td> </tr> <tr> <td data-bbox="1283 878 1923 927">(Print Name and Title) _____</td> </tr> <tr> <td data-bbox="1283 927 1923 976">(Firm Name & Address) _____</td> </tr> <tr> <td data-bbox="1283 976 1923 1040">(Telephone) () Fax # ()</td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date)	(Type or Print Name) <u>Wolfgang Mayer</u>		(Title) <u>Vice President</u>	Paid Preparer	(Signed) _____ (Date)	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) () Fax # ()
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																	
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																	
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																	
	<input type="checkbox"/> "Sub-S" Corp.																																		
	<input type="checkbox"/> Limited Liability Co.																																		
	<input type="checkbox"/> Trust																																		
	<input type="checkbox"/> Other _____																																		
Officer or Administrator of Provider	(Signed) _____ (Date)																																		
	(Type or Print Name) <u>Wolfgang Mayer</u>																																		
	(Title) <u>Vice President</u>																																		
Paid Preparer	(Signed) _____ (Date)																																		
	(Print Name and Title) _____																																		
	(Firm Name & Address) _____																																		
	(Telephone) () Fax # ()																																		

Facility Name & ID Number Bethany Terrace Ret & N H# 0015651 Report Period Beginning: 10/1/00 Ending: 9/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>103</u>	Skilled (SNF)	<u>103</u>	<u>37,595</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>170</u>	Intermediate (ICF)	<u>170</u>	<u>62,050</u>	3
4		Intermediate/DD			4
5	<u>2</u>	Sheltered Care (SC)	<u>2</u>	<u>730</u>	5
6		ICF/DD 16 or Less			6
7	<u>275</u>	TOTALS	<u>275</u>	<u>100,375</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,011</u>	<u>3,503</u>	<u>4,824</u>	<u>11,338</u>	8
9	SNF/PED					9
10	ICF	<u>27,581</u>	<u>51,186</u>		<u>78,767</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>30,592</u>	<u>54,689</u>	<u>4,824</u>	<u>90,105</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 89.77%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)Meals on Wheels

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 2/13/65

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 29 and days of care provided 4,824Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 9/30/01 Fiscal Year: 9/30/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Bethany Terrace Ret & N H

0015651

Report Period Beginning:

10/1/00

Ending:

9/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	545,503	51,113	(108,227)	488,389		488,389	(64,620)	423,769			1
2	Food Purchase		657,856		657,856		657,856		657,856			2
3	Housekeeping	305,454	50,679	50,810	406,943		406,943		406,943			3
4	Laundry	50,710	4,123	240,048	294,881		294,881		294,881			4
5	Heat and Other Utilities			244,078	244,078		244,078		244,078			5
6	Maintenance	175,857	37,625	169,584	383,066		383,066		383,066			6
7	Other (specify):*		85		85		85		85			7
8	TOTAL General Services	1,077,524	801,481	596,293	2,475,298		2,475,298	(64,620)	2,410,678			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	4,984,627	444,607	137,209	5,566,443		5,566,443		5,566,443			10
10a	Therapy	198,348	10,145	196,074	404,567		404,567		404,567			10a
11	Activities	111,691	4,297	29,372	145,360		145,360		145,360			11
12	Social Services	91,199	90	1,507	92,796		92,796		92,796			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Pastoral Care	55,416	361	2,579	58,356		58,356		58,356			15
16	TOTAL Health Care and Programs	5,441,281	459,500	366,741	6,267,522		6,267,522		6,267,522			16
	C. General Administration											
17	Administrative	83,741		438,906	522,647		522,647	(169,911)	352,736			17
18	Directors Fees											18
19	Professional Services			113,550	113,550		113,550	(32,808)	80,742			19
20	Dues, Fees, Subscriptions & Promotions			60,202	60,202	1,126	61,328	(16,940)	44,388			20
21	Clerical & General Office Expenses	218,254	20,850	361,054	600,158		600,158	(23,137)	577,021			21
22	Employee Benefits & Payroll Taxes			683,711	683,711	(1,126)	682,585		682,585			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,108	11,108		11,108		11,108			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			110,379	110,379		110,379		110,379			26
27	Other (specify):*	36,800	4,102	1,937	42,839		42,839	(474)	42,365			27
28	TOTAL General Administration	338,795	24,952	1,780,847	2,144,594		2,144,594	(243,270)	1,901,324			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,857,600	1,285,933	2,743,881	10,887,414		10,887,414	(307,890)	10,579,524			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number **Bethany Terrace Ret & N H**

#0015651

Report Period Beginning:

10/1/00

Ending:

9/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			607,043	607,043		607,043	(12,169)	594,874			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			24,350	24,350		24,350		24,350			35
36	Other (specify):*											36
37	TOTAL Ownership			631,393	631,393		631,393	(12,169)	619,224			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			1,984	1,984		1,984		1,984			41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			1,984	1,984		1,984		1,984			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,857,600	1,285,933	3,377,258	11,520,791		11,520,791	(320,059)	11,200,732			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Bethany Terrace Ret & N H# 0015651Report Period Beginning: 10/1/00Ending: 9/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(64,620)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	56	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(20,857)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(64,727)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (150,148)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(169,911)	17	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (169,911)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (320,059)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Bethany Terrace Ret & NH

ID# 0015651

Report Period Beginning: 10/1/00

Ending: 9/30/01

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Special Revenue	\$ (1,222)	21	1
2	Health Inf. Mgmt Misc. Income	(1,058)	21	2
3	Non-Allowable Marketing	(32,808)	19	3
4	Public Relations	(16,940)	20	4
5	Real Estate	(474)	27	5
6	Depreciation Adjustment	(12,225)	30	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(64,727)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bethany Terrace Ret & N H

0015651

Report Period Beginning:

10/1/00

Ending:

9/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(64,620)	0	0	0	0	0	0	0	0	0	0	(64,620)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(64,620)	0	0	0	0	0	0	0	0	0	0	(64,620)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(169,911)	0	0	0	0	0	0	0	0	0	0	(169,911)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(32,808)	0	0	0	0	0	0	0	0	0	0	(32,808)	19
20	Fees, Subscriptions & Promotions	(16,940)	0	0	0	0	0	0	0	0	0	0	(16,940)	20
21	Clerical & General Office Expenses	(23,137)	0	0	0	0	0	0	0	0	0	0	(23,137)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(474)	0	0	0	0	0	0	0	0	0	0	(474)	27
28	TOTAL General Administration	(243,270)	0	0	0	0	0	0	0	0	0	0	(243,270)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(307,890)	0	0	0	0	0	0	0	0	0	0	(307,890)	29

Summary B

9/30/01

Summary B

[illegible]

Facility Name & ID Number **Bethany Terrace Ret & N H**# **0015651**

Report Period Beginning:

10/1/00

Ending:

9/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	Hospital Admin	\$ 56,350	Methodist Hospital of Chicago	100.00%	\$ 76,525	\$ (56,350)	1
2	V	Hospital Accounting	76,525	Methodist Hospital of Chicago	100.00%	34,584		2
3	V	Hospital EDP	34,584	Methodist Hospital of Chicago	100.00%			3
4	V	Corporate Other	62,087	Methodist Hospital of Chicago	100.00%		(27,939)	4
5	V	Hospital Pastoral Care		Methodist Hospital of Chicago	100.00%			5
6	V	Corporate Prof Fees	41,538	Methodist Hospital of Chicago	100.00%	22,846	(18,692)	6
7	V	Corporate Salary	87,193	Methodist Hospital of Chicago	100.00%	47,956	(39,237)	7
8	V	Corporate Benefits	47,747	Methodist Hospital of Chicago	100.00%	20,054	(27,693)	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 406,024			\$ 236,113	\$ * (169,911)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 Report Period Beginning: 10/1/00 Ending: 9/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Bethany Terrace Ret & N H# 0015651

Report Period Beginning:

10/1/00

Ending:

9/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	Corporate Salary	% to Total Cost	100	Various	\$ 348,770	\$	25	\$ 87,193	1
2									2
3	Corporate Benefits	% to Total Cost	100	Various	190,988		25	47,747	3
4									4
5	Corporate Professional Fees	% to Total Cost	100	Various	166,153		25	41,538	5
6									6
7	Hospital Administration	% to Total Cost	100	Various	225,400		25	56,350	7
8									8
9	Hospital Pastoral Care	% to Total Cost	100	Various	0		50	0	9
10									10
11	Hospital Accounting	% to Total Cost	100	Various	306,098		25	76,525	11
12									12
13	Hospital Data Processing	% to Total Cost	100	Various	384,269		9	34,584	13
14									14
15	Hospital Other	% to Total Cost	100	Various	248,349		25	62,087	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,870,027	\$		\$ 406,024	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

B. Real Estate Taxes

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>			
1. Real Estate Tax accrual used on 2000 report.	\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$		2
3. Under or (over) accrual (line 2 minus line 1).	\$		3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.			
TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$		7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1996	8	
	1997	9	
	1998	10	
	1999	11	
	2000	12	

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME	Bethany Terrace Ret & N H	COUNTY	Cook
---------------	---------------------------	--------	------

CONTACT PERSON REGARDING THIS REPORT

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u>
Index Number	Property Description	Total Tax	Nursing Home

B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet: 92,175

B. General Construction Type:

Exterior

Frame

Number of Stories

C. Does the Operating Entity?

X

(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

X

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

X

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	183,600	1965	\$ 189,809	1
2	Terrace Land Triangle		1996	92,064	2
3	TOTALS	183,600		\$ 281,873	3

Facility Name & ID Number Bethany Terrace Ret & N H

0015651

Report Period Beginning:

10/1/00

Ending:

9/30/01

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	265		1965	1965	\$ 1,332,134	\$ 9,045	40	\$ 9,045		\$ 1,319,739	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10	Paving Stones & Interlocking Paving		2000	2000	5,300	530	10	530		795	10
11	Stoning Grading/Main St.		2000	2000	14,029	1,403	10	1,403		2,104	11
12	Stairs & Concrete Walk Main St. Entrance		2000	2000	4,475	112	40	112		168	12
13	Sealcoat Asbury Parking Lot		2000	2000	2,271	284	8	284		426	13
14	Paving for Bus and Van		2000	2000	3,390	424	8	424		636	14
15	Fence Around Generator		2000	2000	2,491	166	15	166		249	15
16	Terrace Remodeling		2000	2000	284,128	7,103	40	7,103		10,655	16
17	Aluminum Floor In Walk-In Coolers		2000	2000	4,165	417	10	417		625	17
18	Convention Oven		2000	2000	4,792	479	10	479		719	18
19	Garbage Disposal		2000	2000	2,348	470	5	470		705	19
20	Electro Magnetic Locking Devices		2000	2000	10,658	1,066	10	1,066		1,599	20
21	Boiler Upgrade For Dual Fuel Source		2000	2000	5,217	261	20	261		391	21
22	Software For Call Acct. System		2000	2000	3,214	643	5	643		964	22
23	ID Card Reading System		2000	2000	5,831	583	10	583		875	23
24	Mechanical Insulation		1999	1999	22,595	1,130	20	1,130		2,825	24
25	New Doors		1999	1999	9,679	645	15	645		1,613	25
26	Door Replacement/Carpentry		1999	1999	16,901	845	20	845		2,113	26
27	New Piping		1999	1999	2,400	120	20	120		300	27
28	Carpentry		1999	1999	5,041	252	20	252		630	28
29	Chapel Renovation		1999	1999	98,934	4,947	20	4,947		12,367	29
30	Landscaping		1999	1999	10,191	510	20	510		1,275	30
31	Upper Parking Lot Paving		1999	1999	13,450	897	15	897		2,242	31
32	Chapel Dining Hall Sound System		1999	1999	8,550	855	10	855		2,138	32
33	D 336 Motor		1999	1999	1,979	198	10	198		495	33
34	Emergency Generator		1999	1999	184,029	9,201	20	9,201		23,003	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Bethany Terrace Ret & N H

0015651

Report Period Beginning:

10/1/00

Ending:

9/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Vinyl Flooring	1999	\$ 819	\$ 82	10	\$ 82	\$	\$ 205		37
38	Fuel Storage Tank Upgrade	1999	9,360	1,170	8	1,170		2,925		38
39	Bi-Fuel Conversion System	1999	12,400	620	20	620		1,550		39
40	Gasoline For Bi-Fuel Conversion	1999	6,500	325	20	325		813		40
41	Garbage Disposal	1999	1,731	346	5	346		865		41
42	Soil Pipe	1998	2,540	169	15	169		592		42
43	Acoustical Ceiling	1998	1,488	99	15	99		347		43
44	Plate Glass Replacement	1998	2,825	282	10	282		988		44
45	Terrace Remolding	1998	178,041	8,902	20	8,902		31,157		45
46	Generator	1998	695	139	5	139		487		46
47	Electrical	1998	530	26	20	26		92		47
48	Booster Heater	1998	2,417	483	5	483		1,691		48
49	Carpeting	1998	4,766	953	5	953		3,336		49
50	Locknetics Delayed Egress System	1998	2,957	591	5	591		2,069		50
51	MBS Delayed Egress System	1998	1,643	109	15	109		383		51
52	Water Cooler	1998	1,395	93	15	93		325		52
53	Carpeting	1998	1,831	366	5	366		1,281		53
54	Generator	1998	1,286	257	5	257		900		54
55	Window A/C	1998	1,713	343	5	343		1,200		55
56	Ballast Lamp	1998	2,885	577	5	577		2,020		56
57	Convactor Motor	1998	886	89	10	89		311		57
58	Cabinets	1998	2,274	152	15	152		532		58
59	300 Series Tellabs Modem	1998	1,211	242	5	242		847		59
60	PT Day Care Parking	1998	1,372,256	34,306	40	34,306		154,377		60
61	Architectual Building	1998	2,608	261	10	261		1,174		61
62	Roofing	1998	777	39	20	39		175		62
63	Renovation	1998	376	25	15	25		113		63
64	Electrical Lighting	1998	768	38	20	38		171		64
65	Electrical	1997	1,671	83	20	83		376		65
66	Refridgeration	1997	689	69	10	69		310		66
67	Refridgeration Unit Deep Freezer	1997	2,720	272	10	272		1,224		67
68	Wall Hanging	1997	700	140	5	140		630		68
69										69
70	TOTAL (lines 4 thru 69)		\$ 3,682,950	\$ 94,234		\$ 94,234	\$	\$ 1,603,117		70

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

9/30/01

****Improvement type must be detailed in order for the cost report to be considered complete.**

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 9,667,266	\$ 447,661		\$ 447,717	\$ 56	\$ 5,862,972	1
2									2
3	Fixed Equipment	1995	82,231	6,037	various	6,037		41,423	3
4	Fixed Equipment	1994	156,214	10,812	various	10,812		119,198	4
5	Fixed Equipment	1993	50,962	1,251	various	1,251		47,750	5
6	Fixed Equipment	1992	59,368	814	various	814		58,816	6
7	Fixed Equipment	1991	14,721	74	various	74		14,386	7
8	Fixed Equipment	1990	13,740		various			13,740	8
9	Fixed Equipment	1989	23,215		various			23,215	9
10	Fixed Equipment	1988	21,978		various			21,978	10
11	Fixed Equipment	1987	100,453		various			100,453	11
12	Fixed Equipment	1986	89,860		various			89,860	12
13	Fixed Equipment	1985	20,277	567	various	567		18,947	13
14	Fixed Equipment	1984	20,155		various			20,155	14
15	Fixed Equipment	1982	1,830		various			1,830	15
16	Fixed Equipment	1981	1,645		various			1,645	16
17	Fixed Equipment	1980	20,928		various			20,928	17
18	Fixed Equipment	1979	24,316		various			25,316	18
19	Fixed Equipment	1978	3,156		various			3,156	19
20	Fixed Equipment	1977	3,630		various			3,630	20
21	Fixed Equipment	1975	416		various			416	21
22	Fixed Equipment	1974	3,854		various			3,854	22
23	Fixed Equipment	1973	1,960		various			1,960	23
24	Fixed Equipment	1972	410		various			410	24
25	Fixed Equipment	1971	3,018		various			3,018	25
26	Fixed Equipment	1970	9,003		various			9,003	26
27	Fixed Equipment	1968	5,438		various			5,438	27
28	Fixed Equipment	1967	145,657		various			145,657	28
29	Fixed Equipment	1966	62,218		various			62,218	29
30	Fixed Equipment	1965	699,657		various			699,657	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,307,576	\$ 467,216		\$ 467,272	\$ 56	\$ 7,421,029	34

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 11,307,576	\$ 467,216		\$ 467,272	\$ 56	\$ 7,421,029	1
2									2
3	Windows Thermopane	2001	201,057	1,675	40	1,675		1,675	3
4	Remodeling	2001	455,626	7,594	20	7,594		7,594	4
5	Garbage Disposal	2001	2,483	124	5	124		124	5
6	Handicap Drinking Fountain	2001	1,580	105	10	105		1,580	6
7	Nurse Call System	2001	62,523	4,168	10	4,168		4,168	7
8	Bearing Assembly for Circular Pump	2001	1,397	93	10	93		93	8
9	Voice Cabling	2001	6,143	358	10	358		6,143	9
10	Parking Lot Light Pole	2001	2,840	166	10	166		166	10
11	Sprinkling System Valve	2001	635	21	15	21		21	11
12	Phone Cabling	2001	7,180	479	10	479		479	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,049,040	\$ 481,999		\$ 482,055	\$ 56	\$ 7,443,072	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,556,715	\$ 107,695	\$ 107,695	\$	Various	\$ 1,021,039	71
72	Current Year Purchases	87,068	5,124	5,124		Various	5,124	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,643,783	\$ 112,819	\$ 112,819	\$		\$ 1,026,163	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Activities	1988 Ford Van	1988	\$ 35,783	\$	\$	\$		\$ 35,783	76
77	Facility Maintenance	1988 Ford Wagon	1988	16,826					16,826	77
78	Yard Maintenance	International Tractor	1970	3,000					3,000	78
79										79
80	TOTALS			\$ 55,609	\$	\$	\$		\$ 55,609	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 14,030,305	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 594,818	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 594,874	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 56	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,524,844	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ **24,350** Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 2002 \$ _____

13. 2003 \$ _____

14. 2004 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	483	\$ 21,967	\$	483	\$ 21,967	1
2	Licensed Speech and Language Development Therapist		hrs		341	14,782		341	14,782	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	9820 hrs	188,941	95	4,286		9,915	193,227	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Respiratory Therapy	10a	1386	9,408				1,386	9,408	13
14	TOTAL			\$ 198,349	919	\$ 41,035	\$	12,125	\$ 239,384	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Bethany Terrace Ret & N H

0015651

Report Period Beginning: 10/1/00

Ending:

9/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/01

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 1,253,993	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		14,798,488	3
4	Supply Inventory (priced at)		486,365	4
5	Short-Term Investments		10,014,294	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		1,516,803	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		(5,393,255)	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 22,676,688	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		69,051	12
13	Land		6,106,028	13
14	Buildings, at Historical Cost		46,383,266	14
15	Leasehold Improvements, at Historical Cost		1,797,712	15
16	Equipment, at Historical Cost		13,047,384	16
17	Accumulated Depreciation (book methods)		(42,757,868)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		1,886,030	21
22	Other Long-Term Assets (specify):		736,851	22
23	Other(specify):		1,974,500	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 29,242,954	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 51,919,642	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 1,987,512	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		550,000	29
30	Accrued Salaries Payable		2,826,318	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		16,741	33
34	Deferred Compensation		32,918	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Third Party Payors/Residents' Fund		594,155	36
37	Other Current Liabilities		617,499	37
	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 6,625,143	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Estimated Liability for Malpractice Losses		1,196,869	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,196,869	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 7,822,012	46
47	TOTAL EQUITY (page 18, line 24)	\$	\$ 44,097,630	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$	\$ 51,919,642	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 44,067,657	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 44,067,657	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	910,647	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Corporate Income	(880,674)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 29,973	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 44,097,630	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 15,231,629	1
2	Discounts and Allowances for all Levels	(2,914,720)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,316,909	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,772	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	64,620	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	2,280	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 69,672	23
	D. Non-Operating Revenue		
24	Contributions	20,857	24
25	Interest and Other Investment Income***	24,000	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 44,857	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,431,438	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,475,298	31
32	Health Care	6,267,522	32
33	General Administration	2,144,594	33
	B. Capital Expense		
34	Ownership	631,393	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	1,984	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,520,791	40
41	Income before Income Taxes (line 30 minus line 40)**	910,647	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 910,647	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Bethany Terrace Ret & N H**# **0015651**Report Period Beginning: **10/1/00**

Ending:

9/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	45,276	45,276	1,033,960	22.84	3
4	Licensed Practical Nurses	29,152	29,152	521,282	17.88	4
5	Nurse Aides & Orderlies	238,491	238,491	2,540,061	10.65	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	15,386	15,386	365,931	23.78	7
8	Rehab/Therapy Aides	1,833	1,833	34,109	18.61	8
9	Activity Director	7,447	7,447	66,788	8.97	9
10	Activity Assistants					10
11	Social Service Workers	5,672	5,672	80,630	14.22	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	54,413	54,413	501,580	9.22	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	8,608	8,608	154,901	18.00	17
18	Housekeepers	35,059	35,059	276,954	7.90	18
19	Laundry	4,309	4,309	44,693	10.37	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	31,423	31,423	543,008	17.28	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	477,069	477,069	\$ 6,163,897 *	\$ 12.92	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	14,862	\$ 649,542		50
51	Licensed Practical Nurses	1,358	28,052		51
52	Nurse Aides	2,499	46,542		52
53	TOTAL (lines 50 - 52)	18,719	\$ 724,136		53

Facility Name & ID Number

Bethany Terrace Ret & N H

STATE OF ILLINOIS

0015651

Report Period Beginning:

10/1/00

Page 21

Ending: 9/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kenneth Kolich	Administrator		\$ 83,741
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 83,741

B. Administrative - Other

Description	Amount
Corporate Allocation	\$ 438,906
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 438,906

C. Professional Services

Vendor/Payee	Type	Amount
United Methodist Homes		\$ 1,100
Method Management	Mentoring	2,200
MCHC - Service Corp		(6)
Comprehensive Therapeutic	Physical Rehab	12,988
Carol Gordon	Consulting Fees	1,260
Carlin & Associates	Consulting Fees	4,032
Falk Associates	Marketing Fees	30,564
Millman & Robertson	Actuarial Fees	2,244
Accruals	Legal Fees	2,000
Cassiday, Schade & Gloor	Legal Fees	39,821
Diane Cernivivo and Assoc.	Legal Fees	16,907
Schain, Burney, Ross, & Citron	Legal Fees	440
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)		\$ 113,550

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 17,225
Unemployment Compensation Insurance	(655)
FICA Taxes	493,772
Employee Health Insurance	142,938
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	8,406
Union Benefits	5,122
Tuition Reimbursement	450
Other	16,453
TOTAL (agree to Schedule V, line 22, col.8)	\$ 683,711

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	19,368
Health Care Worker Background Check (Indicate # of checks performed)	1,126
Marketing	16,940
Dues & Subscriptions	23,366
Publishing	70
Other	458
Less: Public Relations Expense	(16,940)
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 44,388

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	969
	78
Seminar Expense	10,051
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 11,098

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number **Bethany Terrace Ret & N H**

STATE OF ILLINOIS

0015651

Report Period Beginning:

10/1/00

Ending:

Page 23

9/30/01

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network of IL - \$5,329.37
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,920 Line 10.02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 149,467
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 17,385
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation. N/A
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? None
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: PricewaterhouseCoopers The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.